SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

LSA Staff:

Al Gossard, Fiscal Analyst for the Commission
Casey Kline, Attorney for the Commission

Authority: ***IC 2-5-26***

MEETING MINUTES[1]

Meeting Date:	**September 18, 2002**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Rep. William Crawford, Chairperson; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. Gary Dillon; Sen. Robert Meeks; Sen. Rose Antich; Sen. Samuel Smith .**

Members Absent: **Rep. Charlie Brown; Rep. David Frizzell; Sen. Patricia Miller; Sen. Steve Johnson; Sen. Vi Simpson.**

Rep. William Crawford, Chairperson, called the second meeting of the Select Joint Commission on Medicaid Oversight to order at about 1:00 pm.

Rep. Crawford informed the Commission members that there would be one more meeting of the interim during which legislative proposals could be considered. He reminded members that because there are 12 members, legislative proposals would have to have seven affirmative votes to be officially recommended by the Commission.

Medicaid Waivers

Mr. Steve Cook, Director, Division of Disability, Aging, and Rehabilitative Services, FSSA

Mr. Steve Cook briefed the Commission on three Medicaid home- and community-based waivers that serve people with developmental disabilities: the Developmental Disabilities (DD) waiver (formerly known as the ICF/MR waiver), the Autism waiver, and the Support Services waiver. Mr. Cook provided a handout to members summarizing the eligibility criteria and the

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

services available on each of the waivers (See Exhibit 1).

Mr. Cook explained that the DD waiver was established in 2001, replacing the ICF/MR waiver that had been in existence since 1992. Transportation and health care coordination services were added as covered services when the DD waiver was established. The DD waiver currently is serving 3,781 individuals, with a waiting list of about 8,000 individuals. Mr. Cook explained that some individuals who have been receiving developmental disability services funded with 100% state funds are being moved to the DD waiver in order to take advantage of federal matching funds.

Mr. Cook described the Autism waiver as having been established in 1990 and is currently serving 263 individuals. The waiver has a total of 400 slots and a waiting list of about 1,900 individuals.

Mr. Cook described the Support Services waiver as having been established in April 2002 and is currently serving about 600 individuals. The waiver has 7,000 slots available over a three-year period and currently has no waiting list. He stated that the waiver has a limited number of services and is used often for those individuals who are on the DD waiver waiting list.

Mr. Cook, in response to questions from the Commission, stated that he would provide information on the average length of time spent on waiver waiting lists, the number of children on the waivers, and the average cost of waiver services.

Mr. Doug Beebe, Bureau of Aging, FSSA

Mr. Doug Beebe briefed the Commission on the four Medicaid home- and community-based waivers that serve people with disabilities: the Aged and Disabled waiver, the Medically Fragile Children's waiver, the Traumatic Brain Injury waiver, and the Assisted Living waiver. Mr. Beebe provided a handout to members summarizing the eligibility criteria and the services available on each of the waivers (See Exhibit 2).

Mr. Beebe described the Aged and Disabled (A&D) waiver as being the oldest waiver, having been established in 1983. Originally, the waiver was to serve individuals aged 65 and over, but was amended in 1990 to include the disabled as well. Currently, 3,048 individuals are being served on the waiver, with 2,159 individuals on the waiting list. The state recently released 200 additional slots, and an additional 600 slots are expected to be released soon.

The Medically Fragile Children's waiver was established in 1992 and has a limited set of services. Currently, 136 individuals are receiving services under the waiver, with another 205 individuals on the waiting list.

The Traumatic Brain Injury (TBI) waiver was established in 2000 and currently provides services to 150 individuals, with another 87 individuals on the waiting list.

Mr. Beebe described the Assisted Living waiver (established in 2000) as having 350 slots, but only 18 individuals are being served under the waiver, and there is no waiting list. He stated that this waiver has been difficult to get up and running because individuals have to meet nursing home level of care to be eligible, but it is difficult to find providers willing to offer assisted living services to persons requiring this level of care.

In response to a question, Mr. Beebe indicated that the state was making an effort to convert as many as 800 people who might be eligible for Medicaid from the CHOICE program, which is 100% state-funded, to the A&D waiver to take advantage of federal matching funds.

Mr. Beebe, in response to a question, indicated that he would provide additional information to the Commission on the TBI waiver regarding how many waiver recipients are being provided services outside of Indiana and information regarding the waiver costs.

FSSA staff also provided Commission members with a 35-page booklet, “Indiana Medicaid Home and Community-Based Waiver Services: A Guide for Consumers”, published by the Indiana Governor’s Planning Council for People with Disabilities (September 2002). (See Exhibit 3)

Nursing Home Reimbursement

Ms. Melanie Bella, Assistant Secretary for the Office of Medicaid Policy and Planning (OMPP)

Ms. Melanie Bella, OMPP, provided the Commission with a handout describing the estimated savings from the Phase I and Phase II rules changes affecting nursing home reimbursement. Phase I changes include changes to the case-mix reimbursement system and changes affecting the reimbursement for Medicare crossover claims and the state’s bed hold policy. Phase II changes include more changes to the case-mix system and changes regarding Medicare certification. The estimated annualized savings from all of the changes are $43.7 M in state dollars, or $115.2 M in total Medicaid expenditures. (See Exhibit 4)

Ms. Bella indicated that the most controversial rule change involved the implementation of a 65% occupancy standard for the direct care, indirect care, and administrative components of the case-mix reimbursement system. Ms. Bella stated that the statewide average occupancy rate is about 75%, and a 65% standard was felt to be aggressive in a responsible manner. She added that not all nursing homes had significant excess capacity and that some facilities had waiting lists.

Ms. Bella referenced an Indianapolis Star article that suggested the state was targeting nursing homes for closure with the 65% occupancy standard. Ms. Bella maintained there is no “hit list” of nursing facilities for closure; the list included 89 facilities that were subject to at least a 3% reduction in reimbursement rates because of the rule change. Ms. Bella added that the state does not have access to the financial standings of these facilities.

Mr. Steve Albrecht, Indiana Health Care Association (IHCA)

Mr. Steve Albrecht, IHCA, provided the Commission with a document describing the costs of home care versus nursing home care (see Exhibit 5). Mr. Albrecht stated that IHCA represents more that 300 for-profit and not-for-profit nursing facilities. He stated that he appreciates the meetings with OMPP, although IHCA does not always agree with OMPP.

Mr. Albrecht stated that the case-mix reimbursement system was implemented in 1998, in part, for the purpose of controlling Medicaid costs and slowing the growth in the long term care budget. He added that there are reimbursement caps and limitations already in the system in order to limit payments to nursing facilities. He stated that reimbursement does not cover costs, and the rule changes will only make matters worse with respect to the gap between reimbursement and the costs that nursing facilities incur.

In response to a question, Mr. Albrecht stated that nursing homes are paid per resident and are not paid for empty beds. There are some fixed costs, but the capital cost component of the system has a built-in safety net of a 95% occupancy standard. He added that the reaction of some providers to the rule changes has been to de-license some beds.

Mr. Albrecht stated that the industry has supported a licensing fee and continues to advocate

for such a fee. Mr. Albrecht also stated that the Medicaid forecast was based, in part, on the anticipated cost of the Petricia Day case, but it appears that the costs of the Day case will be much less than projected. Mr. Albrecht concluded by stating that he expects to see additional nursing home closures in the future due to the low reimbursement rates.

Mr. Jim Leich, President, Indiana Association of Homes and Services for the Aging (IAHSA)

Mr. Jim Leich, IAHSA, provided the Commission with a copy of his written testimony (see Exhibit 6). Mr. Leich's written testimony included discussions on the extent of the nursing home cuts, the nature of the changes to the case-mix reimbursement system, the projected impact of the proposed cuts, and recommendations to the General Assembly and OMPP.

Mr. Leich added that nursing home expenditures, while comprising a significant portion of the Medicaid budget, growth in these expenditures has been moderate in recent years; the number of nursing home resident days have actually fallen. Mr. Leich also stated that he hopes nursing home reimbursement cuts will not be permanent and that the state needs to come up with incentives to close down underutilized facilities. He stated that residents are paying what they can; there has been a 14% decline in private pay residents since 1999.

Mr. Patrick Hall, Operator/Owner, Highland Manor Healthcare, Indianapolis

Mr. Patrick Hall, Highland Manor Healthcare, stated that his 70-bed facility was one of the 89 facilities on the list referenced in the Indianapolis Star article described above. He stated that the Medicaid Program and his operation are both charged with providing care to the vulnerable, and risks should be shared to some extent. The welfare of the patient depends upon both Medicaid and the facilities. Mr. Hall added that the recent cuts in the nursing home reimbursement system were budget-driven. He further stated that the State Department of Health's scorecard rated his facility as better than average in the state.

Senator Meeks requested that LSA draft a proposal to eliminate excess licensed beds in nursing facilities.

Ms. Melissa Durr, Indiana Area Agencies on Aging (AAAs)

Ms. Melissa Durr, AAAs, testified about the Pre-Admission Screening (PAS) program that the AAAs conduct. The purpose of pre-admission screening is to ensure that individuals going into nursing homes actually require the level of care that nursing homes provide. Ms. Durr stated that 90% of the people going into nursing homes do so directly from the hospital. Consequently, PAS screenings are performed retroactively, and once individuals are in nursing homes, it is often difficult to return them to the community. She added that the PAS program does not work as well as it should.

Access to Prenatal Care in Elkhart County

Ms. Melanie Bella, OMPP

Ms. Melanie Bella, OMPP, addressed the problem of limited access to prenatal care in Elkhart County. Ms. Bella stated that there has been a shortage of OB/GYNs affiliated with the Medicaid managed care organizations (MCOs), and the OB/GYNs prefer to work in the hospitals and are reluctant to provide prenatal care. Ms. Bella stated that she believes the problem is now, in large part, under control.

The northern region of the state is served by two managed care organizations: Managed Health Services (MHS) and Harmony Health Management. Ms. Bella stated that MHS, Harmony, and

OMPP are working together toward a solution to this problem. She added that a possible solution is that doctors will supervise nurse mid-wives who would provide prenatal care. OMPP and the MCOs are also continuing to talk to the doctors to encourage them to provide prenatal services. Ms. Bella stated that the reason typically given for the shortage of OB/GYN services is that Medicaid reimbursement is too low.

Ms. Rita Mills, President and Chief Executive Officer, Managed Health Services

Ms. Rita Mills, MHS, suggested that problem of access to prenatal care services was being managed, and the problem was more associated with the city of Elkhart than with Elkhart County. She stated that the OB/GYNs had not been willing to contract with the MCOs, however, the doctors could work on an out-of-network basis. She added that there are 35 OB/GYNs in Elkhart that contract with MHS.

Dr. Tammaji P. Kulkarni, Medical Director, Harmony Health Management

Dr. Tammaji P. Kulkarni, Harmony Health Management, stated that Harmony serves 15% of the Medicaid recipients in Elkhart, while MHS serves 85%. He added that he had participated in a meeting the previous day, and the local clinic was looking to hire two more doctors and was also looking for additional funding.

Ms. Stephanie Dekemper, President and CEO, Indiana Minority Health Coalition, Inc.

Ms. Stephanie Dekemper, Indiana Minority Health Coalition, stated that she was representing a patient advocacy group and that she was requesting that the Commission continue to monitor this situation. Ms. Dekemper stated that she was concerned that high-risk women (e.g., those with HIV/AIDS, diabetes, etc.) would not be able to receive the level of care that they need. She added that she does not believe that the problem is solved. She added that the infant mortality rate in Elkhart is much higher than the state average.

Ms. Elizabeth Merchiers, Indiana State Medical Association (ISMA)

Ms. Elizabeth Merchiers, ISMA, stated that there were different stories coming out of Elkhart and she believes there is still a crisis. Ms. Merchiers stated that she has talked with the doctors in Elkhart and they also believe there is still a crisis. She also suggested that the MCO contracts are problematic. Ms. Merchiers also advised against creating a two-tiered health care system, where private insureds would have access to an OB/GYN while Medicaid recipients would only have access to nurse midwives during prenatal care.

Medicaid Rehab Option (MRO)

Mr. John Boyce, Director, Division of Family and Children, FSSA

Mr. John Boyce, Division of Family and Children, stated that the Medicaid Rehab Option is purely a funding mechanism for community-based services and has existed since 1991. The community mental health centers (CMHCs) provide the services and the Division of Mental Health and Addiction Services administers the program. Services include diagnostic assessment, crisis intervention, medication, family counseling, case management, and partial hospital services. FY 2000 Medicaid-paid services totaled about $184.5 M, $70.7 M of which was the state share. Medicaid-eligible clients include both adults and children. (Additional information was requested by the Commission regarding children's services and the population served by the MRO.)

Mr. Boyce explained that the state is proposing a further expansion of the Medicaid Rehab

Option. He stated that currently the MRO is limited to CMHCs, but that the state is planning on bringing in additional providers who can bill through Medicaid. He added that local Family and Children Fund expenditures already being used for these services would be considered as the state match, thus accessing more federal dollars (an estimated $17 M) with no additional state expenditures. Implementation of the expansion is anticipated to be completed by October 2003.

Mr. James Hurst, Indiana Council of Community Mental Health Centers, Inc.

Mr. James Hurst, Indiana Council of Community Mental Health Centers, stated that the state match is currently part of the line item in the budget for the CMHCs. The line item is apportioned by the Division of Mental Health and Addiction Services to the providers, and the allocation differs by contract.

Mr. Galen Goode, Hamilton Center, Inc.

Mr. Galen Goode, Hamilton Center, one of Indiana's CMHCs, stated that the MRO is a great program, but that the funding continues to be a problem because of the state appropriation which acts as a cap on services and funding.

In response to a question from the Commission, Ms. Melanie Bella stated that OMPP would provide a breakdown of MRO dollars and who received the MRO funding for the last two years.

There being no further business to conduct, the meeting was adjourned.

[Note: A memo prepared by OMPP was distributed to Commission members in advance of the meeting and provided followup information from the Commission meeting held August 12, 2002. This document is available as Exhibit 7 and addresses questions regarding pharmacy benefit management, disease management/case management, Medicare crossover claims, enrollment and expenditure data, and Medicaid administration account expenditures.]